Attachment A – HMA Experience

Design and Implementation of Uninsured Programs

Health Management Associates (HMA) is one of the nation's leading firms in the development of local, community based-approaches to the expansion of access to health care. HMA has worked with more than a dozen communities to implement programs that meet community needs. Several of these programs are highlighted below.[1]

These examples illustrate a successful and replicable approach to addressing the issue of the uninsured. As discussed in the proposal narrative, this approach uses a defined decision-making process to harness community input and HMA's technical expertise. Many of these examples also utilized a plan pricing model developed by HMA and its actuarial subcontractor, Donlon and Associates,[2] which allows communities to assess the financial impact of various plan design features.

Rockford (Illinois) Health Council: September 2001 to present

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HMA worked with the Rockford Health Council to design a health insurance program for small businesses in Winnebago County. The program is scheduled to launch in March 2003 and is expected to provide coverage to as many as 5,000 previously uninsured individuals. HMA continues to provide technical and operational assistance to the Rockford Health Council on its uninsured health coverage program. HMA's specific activities included:

- Identification of community needs and development of concept for the appropriate indigent care program. In this case, Rockford decided to go with a small employer-based, third-share model;
- Development/creation of the nonprofit corporation (including its governance and administrative structure);

[1] HMA has also worked with or is working with 12 additional communities in Michigan as well as communities in Ohio and Florida on programs to cover the uninsured. Information on any of these projects is available upon request.

[2] Depending on the Department's preference and the availability of the Department's actuary, HMA may engage our own actuarial subcontractor, Donlon and Associates, on this project. HMA's cost proposal includes actuarial subcontractor costs.

- Development of program specifications (benefit structure);
- Development of overall program and financing strategy, including continued review and identification of local funds that qualify as matching funds;
- Budget development and refinements;
- Development of provider reimbursement rates/schedules;
- Assist development of Provider agreements;
- Provider network development;
- Development and management of relationships with the Illinois Department of Insurance;
- Analysis of utilization and cost trends for potential plan enrollees;
- Assistance with design of program administration; and
- Attendance at Board meetings until implementation completed.

Macoupin (Illinois) County Public Health Department: Summer 2002 to present

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HMA is currently working with the Macoupin County Public Health Department to design a health insurance program for small businesses in the County. Activities are similar to those performed in Rockford and include:

- Identification of community needs and development of concept for the appropriate indigent care program. Like Rockford, Macoupin decided to go with a small employer-based, third-share model;
- Development/creation of the nonprofit corporation (including its governance and administrative structure);
- Development of program specifications (benefit structure);
- Development of overall program and financing strategy, including continued review and identification of local funds that qualify as matching funds;
- Budget development and refinements;
- Development of RFP and negotiations with bidders (insurance companies);

- Development and management of relationships with the Illinois Department of Insurance;
- Analysis of utilization and cost trends for potential plan enrollees;
- Assistance with design of program administration; and
- Attendance at planning meetings until implementation completed.

Ingham (Michigan) County Health Department: 1997 to present

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HMA played an integral role in the initiation of this community-based program that provides coordinated coverage for ambulatory health care for indigent and low-income individuals in Ingham County, Michigan. This program became operational in October 1998 and currently covers approximately 15,000 individuals. HMA assisted with development of the revenue sources, design of the benefit package, and establishment of many of the administrative functions, including pharmacy benefits management. HMA continues to advise the Ingham Health Plan (IHP) board as they refine the design of IHP. In addition, HMA is working with Ingham County to implement a subsidy program for low wage businesses. This program is expected to begin marketing activities in April 2003.

Muskegon Health Plan: Spring 1999 to Present

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Muskegon County began administering its three-share program through the Access Health Corporation in the spring of 1999. Access Health is a 501(m) corporation and is incorporated under Michigan's Municipal Health Facilities Corporation Act. A community board governs Access Health. Access Health intends to subsidize 3,000 enrollees; enrollment is currently about 800 members. Access Health benefits are delivered through a contracted, county-wide provider network. Members select a primary care physician. It is the responsibility of primary care physicians to refer patients for specialty care, diagnostic tests and other necessary services. Care is only covered within the County. Services received outside of the county, including emergency services and

specialty services not available within the county, are not covered. Three full-time Access Health employees provide case management services. Providers are paid fee-for-service, minus applicable copayments and a 10% provider donation toward the member's total cost of coverage. Access Health members enroll through their employer. A contracted Third Party Administrator (TPA) processes claims.

Coverage. The Access Health basic scope of services includes physician services, inpatient hospital care, emergency room visits, home health, diagnostic ancillary services such as lab and x-ray, ambulance and prescription drugs. A range of copays applies to certain services. Limited mental health and chemical dependency services are also covered. Supplemental riders are not offered.

Kent Health Plan Corporation: 2000 to Present

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Kent Health Plan Corporation (KHPC) was established in 2001 as a 501(c)(4) non-profit organization. KHPC issued an RFP for its three-share program in January 2002, and the program is currently operational. Subsidies are limited to 2,500 enrollees and KHPC anticipates reaching that enrollment by 2004.

KHPC subsidies will be available for coverage of employees and dependent spouses, but will not be contributed toward the cost of minor dependent coverage as it is assumed that these children will be eligible for coverage under the MIChild program. Employers must meet the following criteria to be eligible for coverage. The primary business location must be in Kent County. The employer must have acted as an employer for two years and not offered or contributed to health care benefits for employees in the same or similar job classification for the past two years. Employers must employ four but not more than 200 employees, and at least half of all employees must have an hourly wage of $10 or less.

The employee must work for a qualified employer, have an anticipated work future of more than six months, be without health care benefits at the time of enrollment and not eligible for government or other employer-sponsored coverage.

State Planning Activities

HMA has worked with many states to help them understand the characteristics of their uninsured populations and design approaches for reducing the ranks of the uninsured. Several of these projects are detailed below.

Delaware Health Care Commission: April 2001 to August 2002

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Health Management Associates in conjunction with activities undertaken as part of Delaware's HRSA State Planning Grant assisted Delaware in answering the following questions:

- Who are the uninsured, and what are their characteristics?
- What are the barriers that prevent the uninsured from getting coverage?
- How can these barriers be overcome?
- What will it cost?
- Who will pay the costs?
- How can a consensus be developed around the chosen strategies?

Tasks included reviewing existing reports and past efforts to extend coverage; reviewing data that documents the extent and nature of the problem; carrying out research to determine the barriers that prevent the uninsured from getting health coverage; reviewing innovative efforts in other states and opportunities provided by federal law; conducting insurance market place analysis; preparing possible range of options that outline the policies Delaware could pursue to expand coverage to uninsured populations in the state; and refining the analysis of possible policy options, selecting the policies to be recommended for implementation, and preparing specific and detailed actuarial analysis of the policy options.

HMA, with Donlon & Associates as actuarial subcontractor, developed an actuarial model for projecting the costs of all possible policy options. This model is available and appropriate for use in our projects developing coverage for the uninsured, and is particularly relevant to the Illinois Pilot, upon which a statewide replication could be priced.

Indiana Health Insurance Survey: December 1999 to February 2001

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HMA and the University of Florida developed a survey instrument to provide current estimates of the number and percentage of Indiana's non-elderly residents who are uninsured. Particularly, the survey provided information on non-elderly residents who are uninsured by several demographic and economic categories including age, race, gender, county, income, employment status, marital status, ethnic identification, industry of employment and size of employer. Over 10,000 households were surveyed, and the analysis of the survey results were presented to the state Health Policy Board.

Indiana Health Coverage Expansion Services: December 1999 to November 2001

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HMA provided consulting services to the State of Indiana on developing a range of policy options to extend health coverage to uninsured populations of the state. HMA's responsibilities included assisting the Health Policy Board and the Health Insurance for Indiana Families Committee in laying out implications of ERISA limitations, identifying the full range

Maryland Small Group Health Insurance Report: October 2000 to April 2001

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In the 2001 legislative session, the Maryland legislature passed House Bill 695/Senate Bill 457, which required a study to compare the performance of Maryland's small-group health-insurance market reform law to that of other states. The fundamental question which this study addresses is: Are there elements of Maryland's reforms that might be altered in a way that would improve access to affordable coverage-that is, to cause more small employers to offer coverage and more employees to accept it-without creating other adverse consequences? Special scrutiny is directed to the scope of benefits in the Standard Plan and to the reforms that limit insurers' ability to vary premiums based on the characteristics of small groups.

The study compares small-group reforms and performance in Maryland with six other states-New Jersey, Delaware, Virginia, North Carolina, Florida, and Colorado-and to the United States as a whole. The study uses data from a variety of sources: interviews with insurance agents and brokers, state regulatory officials, and health plans executives in all the study states; the Medical Expenditure Panel Survey, a national survey of the federal Agency for Healthcare Research and Quality; a special survey of state premium differences conducted for this study by the National Association of Health Underwriters; and research literature related to small-group market reforms and performance. We assessed the performance of Maryland's small group market in the following six areas:

1. Coverage rates for small groups
2. Average cost of coverage
3. Cost of coverage for common health benefits
4. Affordability
5. Premium trends
6. Degree of competition